California Department of Health Care Services
Proposed May Revision Trailer Bill Legislation

Transfer of Medi-Cal Functions from DMH to DHCS

Chapter 8.9 (commencing with Section 14700) is added to Part 3 of Division 9 of the Welfare and Institutions Code to read:

Section 14700 of the Welfare and Institutions Code is added to read:
It is the intent of the Legislature, in enacting this act, to transferto the State Department of Health Care Services, no later than July 1, 2012,Medi-Cal mental health care functions currently administered through the State Department of Mental Health, without regard to whether or not that Medi-Cal mental health function has been formally created by statute.

Section 14701 of the Welfare and Institutions Code is added to read:
The State Department of Mental Health's administration of the Medi-Cal mental health functions is hereby transferred to the department effective June 30, 2012.

Section 14702 of the Welfare and Institutions Code is added to read:
As used in this chapter:
(a) "department" means the State Department of Health Care Services.
(b) "director" means the Director of the Department of Health Care Services.

Section 14703 of the Welfare and Institutions Code is added to read:
Notwithstanding section 14701, the department and the State Department of Mental Health shall, before July 1, 2012, conduct transition activities necessary to ensure the efficient transfer of Medi-Cal mental health functions.

Section 14704 ofthe Welfare and Institutions Code is added to read:

Notwithstanding section 14701, upon the effective date of this act, the Governor is authorized to make final decisions about the placement of specific programs and offices that are not named in this act in a way that is consistent with the intent of the Legislature in enacting this act.

Section 14705 the Welfare and Institutions Code is added to read:

(a) All regulations and orders concerning Medi-Cal mental health adopted by the State Department Mental Health in effect preceding the operative date of this section shall remain in effect and shall be fully enforceable unless and until readopted, amended or repealed by the department, or until such regulations and orders expire by their own terms.

(b) Notwithstanding subdivision (a) or Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, for purposes of Medi-Cal mental health, the department may implement, interpret, or make specific this part and amend or repeal regulations and orders adopted by the State Department of Mental Health by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions without taking regulatory action.

Section 5718 of the Welfare and Institutions Code is amended and renumbered as Section 14706:

(a)(1) This section ~~and Sections 5719 to 5724, inclusive,~~ shall apply to mental health services provided by counties to Medi-Cal eligible individuals. Counties shall provide services to Medi-Cal beneficiaries and seek the maximum federal reimbursement possible for services rendered to the mentally ill.

(2) To the extent permitted under federal law, funds deposited into the local health and welfare trust fund from the Sales Tax Account of the Local Revenue Fund may be used to match federal ~~m~~Medicaid funds in order to achieve the maximum federal reimbursement possible for services pursuant to this chapter. If a county applies to use local funds, the department may enforce any additional federal requirements that use

may involve, based on standards and guidelines designed to enhance, protect, and maximize the claiming of those resources.

(3) The standards and guidelines for the administration of mental health services to Medi-Cal eligible persons shall be based on federal ~~m~~Medicaid requirements.

(b) With regard to each person receiving mental health services from a county mental health program, the county shall determine whether the person is Medi-Cal eligible and, if determined to be Medi-Cal eligible, the person shall be referred when appropriate to a facility, clinic, or program which is certified for Medi-Cal reimbursement.

(c) With regard to county operated facilities, clinics, or programs for which claims are submitted to the department for Medi-Cal reimbursement for mental health services to Medi-Cal eligible individuals, the county shall ensure that all requirements necessary for Medi-Cal reimbursement for these services are complied with, including, but not limited to, utilization review and the submission of year-end cost reports by December 31 following the close of the fiscal year.

(d) Counties shall certify to the state that required matching funds are available prior to the reimbursement of federal funds.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in this section by means of provider bulletins or notices, policy letters, or other similar instructions without taking regulatory action.

Section 5716 is of the Welfare and Institutions Code amended and renumbered as Section 14707:

Counties may contract with providers on a negotiated rate or negotiated net amount basis ~~in the same manner as set forth in Section 5705~~, except that negotiated rates for Short-Doyle Medi-Cal services shall be approved by the department. If a negotiated rate

for Short-Doyle Medi-Cal services is not approved by the department reimbursement to the county shall be in accordance with applicable provisions of this chapter and department regulation or other similar instruction~~and shall be based upon actual cost~~.

Section 5722 of the Welfare and Institutions Code is amended and renumbered as Section 14708:

(a) The department shall have responsibility, ~~as delegated by the State Department of Health Services,~~ for conducting investigations and audits of claims and reimbursements for expenditures for mental health services provided by county mental health programs to Medi-Cal eligible individuals.

(b) The amount of the payment or repayment of federal funds in accordance with audit findings pertaining to Short-Doyle Medi-Cal mental health services shall be determined by the department~~State Director of Health Services~~ pursuant to the existing administrative appeals process of the department~~State Department of Health Services~~.

(c) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in this section by means of provider bulletins or notices, policy letters, or other similar instructions without taking regulatory action.

Section 5711 of the Welfare and Institutions Code is amended and renumbered as Section 14709:

(a) In the case of federal audit exceptions, federal audit appeal processes shall be followed unless the department ~~State Department of Mental Health~~, in consultation with the California ~~Conference of Local~~ Mental Health DirectorsAssociation, determines that those appeals are not cost beneficial.

(b) Whenever there is a final federal audit exception against the state resulting from expenditure of federal funds by individual counties, thedepartment~~State Department of~~

~~Mental Health or the State Department of Health Services~~ may request the Controller's office to offset the county's allocation from the Mental Health Subaccount of the Sales Tax Account of the Local Revenue Fund by the amount of the exception. The Controller shall be provided evidence that the county has been notified of the amount of the audit exception no less than 30 days before the offset is to occur~~.~~ The department~~State Department of Mental Health and the State Department of Health Services~~ shall involve the appropriate counties in developing responses to any draft federal audit reports which may directly impact the counties.

Section 5720 of the Welfare and Institutions Code is renumbered as 14710:

(a) Notwithstanding any other provision of law, the director, in the 1993-94 fiscal year and fiscal years thereafter, subject to the approval of the director, shall establish the amount of reimbursement for services provided by county mental health programs toMedi-Cal eligible individuals.

(b) Notwithstanding this section, in the event that a health facility has entered into a negotiated rate agreement pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9, the facility's rates shall be governed by that agreement.

Section 5723 of the Welfare and Institutions Code is renumbered as Section 14711:

The provisions of subdivision (a) of Section 14000 shall not be construed to prevent providers of mental health services pursuant to this part from also being providers of medical assistance mental health services for the purposes of Chapter 7 (commencing with Section 14000) of Part 3 of Division 9. Clinics providing mental health services pursuant to this part shall not be required to be licensed as a condition to reimbursement for providing such medical assistance mental health services.

Section 5721 of the Welfare and Institutions Code is renumbered as Section 14712:

Except as otherwise provided in this section, in determining the amounts which may be paid, fees paid by persons receiving services or fees paid on behalf of persons receiving services by the federal government, by the California Medical Assistance Program set forth in Chapter 7 (commencing with Section 14000) of Part 3 of Division 9, and by other public or private sources, shall be deducted from the costs of providing services. However, a county may negotiate a contract which permits a mental health care provider to retain unanticipated funds above the budgeted contract amount, provided that the unanticipated revenues are utilized for the mental health services specified in the contract. If a provider is permitted by contract to retain unanticipated revenues above the budgeted amount, the mental health provider shall specify the services funded by those revenues in the year end cost report submitted to the county. A county shall not permit the retention of any fees paid by private resources on behalf of Medi-Cal beneficiaries without having those fees deducted from the costs of providing services. Whenever feasible, mentally disordered persons who are eligible for mental health services under the California Medical Assistance Program shall be treated in a facility approved for reimbursement in that program. General unrestricted or undesignated private charitable donations and contributions made to charitable or nonprofit organizations shall not be considered as “fees paid by persons” or “fees paid on behalf of persons receiving services” under this section and the contributions shall not be applied in determining the amounts to be paid. These unrestricted contributions shall not be used in part or in whole to defray the costs or the allocated costs of the California Medical Assistance Program.

Section 5723.5 of the Welfare and Institutions Code is renumbered as Section 14713:

Notwithstanding any other provision of state law, and to the extent permitted by federal law and consistent with federal regulations governing these claims, the state may seek federal reimbursement for back claims under the Short-Doyle Medi-Cal program.

Section 5724 of the Welfare and Institutions Code is amended and renumbered as Section 14714:

(a) The department ~~and the State Department of Health Services~~ shall ~~jointly~~ develop a ~~new~~ ratesetting methodology for use in the Short-Doyle Medi-Cal system that maximizes federal funding and utilizes, as much as practicable, federal ~~m~~Medicare reimbursement principles. The department~~s~~ shall work with the counties and the federal ~~Health Care Financing Administration~~ Centers for Medicare and Medicaid Services in the development of the methodology required by this section.

(b) Rates developed through the methodology required by this section shall apply only to reimbursement for direct client services.

(c) Administrative costs shall be claimed separately and shall be limited to 15 percent of the total cost of direct client services.

(d) The cost of performing utilization reviews shall be claimed separately and shall not be included in administrative cost.

(e) The ratesetting methodology established pursuant to this section shall ~~contain incentives relating to~~consider economy and efficiency in service delivery.

(f) The rates established for direct client services pursuant to this section shall be based on increments of time for all non-inpatient services.

(g) The ratesetting methodology shall not be implemented until it has received any necessary federal approvals.

(h) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in this section by means of provider bulletins or notices, policy letters, or other similar instructions without taking regulatory action.

Section 5775 of the Welfare and Institutions Code is amended and renumbered as 14715:

(a) Notwithstanding any other provision of state law, the ~~State Department of Mental Health~~department shall implement managed mental health care for Medi-Cal beneficiaries through fee-for-service or capitated rate contracts with mental health plans.~~, including individual counties, counties acting jointly, any qualified individual or organization, or a nongovernmental entity. A contract may be exclusive and may be awarded on a geographic basis.~~

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of mental health services. The agreement may encompass all or any portion of the mental health services provided pursuant to this part. This agreement shall not relieve the individual counties of financial responsibility for providing these services. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

~~(c) The department shall offer to contract with each county for the delivery of mental health services to that county's Medi-Cal beneficiary population prior to offering to contract with any other entity, upon terms at least as favorable as any offered to a noncounty contract provider. If a county elects not to contract with the department, does not renew its contract, or does not meet the minimum standards set by the department, the department may elect to contract with any other governmental or nongovernmental entity for the delivery of mental health services in that county and may administer the delivery of mental health services until a contract for a mental health plan is implemented. The county may not subsequently contract to provide mental health services under this part unless the department elects to contract with the county.~~

~~(d) If a county does not contract with the department to provide mental health services, the county shall transfer the responsibility for community Medi-Cal reimbursable mental health services and the anticipated county matching funds needed for community Medi-Cal mental health services in that county to the department. The amount of the~~

~~anticipated county matching funds shall be determined by the department in consultation with the county, and shall be adjusted annually. The amount transferred shall be based on historical cost, adjusted for changes in the number of Medi-Cal beneficiaries and other relevant factors. The anticipated county matching funds shall be used by the department to contract with another entity for mental health services, and shall not be expended for any other purpose but the provision of those services and related administrative costs. The county shall continue to deliver non-Medi-Cal reimbursable mental health services in accordance with this division, and subject to subdivision (i) of Section 5777.~~

(~~e~~c) Whenever the department determines that a mental health plan has failed to comply with this part or any regulations or similar instructions adopted pursuant to this part that implement this part, the department may impose sanctions, including, but not limited to, fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to prompt and ensure contract and performance compliance. If fines are imposed by the department, they may be withheld from the state matching funds provided to a mental health plan for Medi-Cal mental health services.

~~(f) Notwithstanding any other provision of law, emergency regulations adopted pursuant to Section 14680 to implement the second phase of mental health managed care as provided in this part shall remain in effect until permanent regulations are adopted, or June 30, 2006, whichever occurs first.~~

~~(g) The department shall convene at least two public hearings to clarify new federal regulations recently enacted by the federal Centers for Medicare and Medicaid Services that affect the state's second phase of mental health managed care and shall report to the Legislature on the results of these hearings through the 2005-06 budget deliberations.~~

~~(h) The department may adopt emergency regulations necessary to implement Part 438 (commencing with Section 438.1) of Subpart A of Subchapter C of Chapter IV of Title 42 of the Code of Federal Regulations, in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The adoption of emergency regulations to implement this part, that are filed with the Office of Administrative Law within one year of the date on which the act that amended this subdivision in 2003 took effect, shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare, and shall remain in effect for no more than 180 days.~~

(d) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in this section by means of provider bulletins or notices, policy letters, or other similar instructions without taking regulatory action.

(e) Contracts entered into pursuant to this section shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

Section 5776 of the Welfare and Institutions Codeis amended and renumbered as Section 14716:

(a) The department and its mental health plan contractors shall comply with all applicable federal laws, regulations, and guidelines, and, except as provided in this part, all applicable state statutes and regulations.

(b) If federal requirements that affect the provisions of this part are changed, it is the intent of the Legislature that state requirements be revised to comply with those changes.

Section 5777 of the Welfare and Institutions Code is amended and renumbered as Section 14717:

(a)(1) Except as otherwise specified in this part, a contract entered into pursuant to this part shall include a provision that the mental health plan contractor shall bear the financial risk for the cost of providing medically necessary mental health services to Medi-Cal beneficiaries irrespective of whether the cost of those services exceeds the payment set forth in the contract. If the expenditures for services do not exceed the payment set forth in the contract, the mental health plan contractor shall report the unexpended amount to the department, but shall not be required to return the excess to the department.

(2) If the mental health plan is not the county's, the mental health plan may not transfer the obligation for any mental health services to Medi-Cal beneficiaries to the county. The mental health plan may purchase services from the county. The mental health plan shall establish mutually agreed-upon protocols with the county that clearly establish conditions under which beneficiaries may obtain non-Medi-Cal reimbursable services from the county. Additionally, the plan shall establish mutually agreed-upon protocols with the county for the conditions of transfer of beneficiaries who have lost Medi-Cal eligibility to the county for care under Part 2 (commencing with Section 5600), Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850).

(3) The mental health plan shall be financially responsible for ensuring access and a minimum required scope of benefits, consistent with state and federal requirements, to the services to the Medi-Cal beneficiaries of that county regardless of where the beneficiary resides. The department shall require that the definition of medical necessity used, and the minimum scope of benefits offered, by each mental health contractor be the same, except to the extent that any variations receive prior federal approval and are consistent with state and federal statutes and regulations.

(b) Any contract entered into pursuant to this part may be renewed if the mental health plan continues to meet the requirements of this part, regulations promulgated pursuant thereto or other similar instructions, and the terms and conditions of the contract. Failure to meet these requirements shall be cause for non-renewal of the contract. The department may base the decision to renew on timely completion of a mutually agreed-upon plan of correction of any deficiencies, submissions of required information in a

timely manner, or other conditions of the contract. At the discretion of the department, each contract may be renewed for a period not to exceed three years.

(c)(1) The obligations of the mental health plan shall be changed only by contract or contract amendment.
(2) A change may be made during a contract term or at the time of contract renewal, where there is a change in obligations required by federal or state law or when required by a change in the interpretation or implementation of any law, ~~or~~ regulation, or other similar instruction. To the extent permitted by federal law ~~and except as provided under paragraph (10) of subdivision (c) of Section 5778~~, if any change in obligations occurs that affects the cost to the mental health plan of performing under the terms of its contract, the department may reopen contracts to negotiate the state General Fund allocation to the mental health plan under Section ~~5778~~14721, if the mental health plan is reimbursed through a fee-for-service payment system, or the capitation rate to the mental health plan under Section ~~5779~~14723, if the mental health plan is reimbursed through a capitated rate payment system. During the time period required to redetermine the allocation or rate, payment to the mental health plan of the allocation or rate in effect at the time the change occurred shall be considered interim payments and shall be subject to increase or decrease, as the case may be, effective as of the date on which the change is effective.
(3) To the extent permitted by federal law, either the department or the mental health plan may request that contract negotiations be reopened during the course of a contract due to substantial changes in the cost of covered benefits that result from an unanticipated event.

(d) The department shall immediately terminate a contract when the director finds that there is an immediate threat to the health and safety of Medi-Cal beneficiaries. Termination of the contract for other reasons shall be subject to reasonable notice of the department's intent to take that action and notification of affected beneficiaries. The plan may request a public hearing by the Office of Administrative Hearings.

~~(e) A plan may terminate its contract in accordance with the provisions in the contract. The plan shall provide written notice to the department at least 180 days prior to the termination or non-renewal of the contract.~~

~~(f)~~(e)Upon the request of the ~~D~~director~~of Mental Health~~, the Director of Managed Health Care may exempt a mental health plan contractor or a capitated rate contract from the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). These exemptions may be subject to conditions the director deems appropriate. Nothing in this part shall be construed to impair or diminish the authority of the Director of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, nor shall anything in this part be construed to reduce or otherwise limit the obligation of a mental health plan contractor licensed as a health care service plan to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of Managed Health Care promulgated thereunder. The ~~D~~director~~of Mental Health~~, in consultation with the Director of Managed Health Care, shall analyze the appropriateness of licensure or application of applicable standards of the Knox-Keene Health Care Service Plan Act of 1975.

~~(g)(1)~~(f)The department, pursuant to an agreement with the State Department of Health Care Services, shall provide oversight to the mental health plans to ensure quality, access, and cost efficiency. At a minimum, the departmentshall, through a method independent of any agency of the mental health plan contractor, monitor the level and quality of services provided, expenditures pursuant to the contract, and conformity with federal and state law.

~~(2)(A) Commencing July 1, 2008, county mental health plans, in collaboration with the department, the federally required external review organization, providers, and other stakeholders, shall establish an advisory statewide performance improvement project (PIP) to increase the coordination, quality, effectiveness, and efficiency of service delivery to children who are either receiving at least three thousand dollars ($3,000) per month in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)~~

~~Program services or children identified in the top 5 percent of the county EPSDT cost, whichever is lowest. The statewide PIP shall replace one of the two required PIPs that mental health plans must perform under federal regulations outlined in the mental health plan contract.~~

~~(B) The federally required external quality review organization shall provide independent oversight and reviews with recommendations and findings or summaries of findings, as appropriate, from a statewide perspective. This information shall be accessible to county mental health plans, the department, county welfare directors, providers, and other interested stakeholders in a manner that both facilitates, and allows for, a comprehensive quality improvement process for the EPSDT Program.~~

~~(C) Each July, the department, in consultation with the federally required external quality review organization and the county mental health plans, shall determine the average monthly cost threshold for counties to use to identify children to be reviewed who are currently receiving EPSDT services. The department shall consult with representatives of county mental health directors, county welfare directors, providers, and the federally required external quality review organization in setting the annual average monthly cost threshold and in implementing the statewide PIP. The department shall provide an annual update to the Legislature on the results of this statewide PIP by October 1 of each year for the prior fiscal year.~~

~~(D) It is the intent of the Legislature for the EPSDT PIP to increase the coordination, quality, effectiveness, and efficiency of service delivery to children receiving EPSDT services and to facilitate evidence-based practices within the program, and other high-quality practices consistent with the values of the public mental health system within the program to ensure that children are receiving appropriate mental health services for their mental health wellness.~~

~~(E) This paragraph shall become inoperative on September 1, 2011.~~

~~(h) County employees implementing or administering a mental health plan act in a discretionary capacity when they determine whether or not to admit a person for care or to provide any level of care pursuant to this part.~~

~~(i) If a county chooses to discontinue operations as the local mental health plan, the new plan shall give reasonable consideration to affiliation with nonprofit community mental health agencies that were under contract with the county and that meet the mental health plan's quality and cost efficiency standards.~~

(~~j~~g) Nothing in this part shall be construed to modify, alter, or increase the obligations of counties as otherwise limited and defined in Chapter 3 (commencing with Section 5700) of Part 2. The county's maximum obligation for services to persons not eligible for Medi-Cal shall be no more than the amount of funds remaining in the mental health sub-account pursuant to Sections 17600, 17601, 17604, 17605, 17606, and 17609 after fulfilling the Medi-Cal contract obligations.

(h) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in this section by means of provider bulletins or notices, policy letters, or other similar instructions without taking regulatory action.

(i)Contracts entered into pursuant to this section shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code

Section 5777.5 of the Welfare and Institutions Code is renumbered as Section 14718:

(a)(1) The department shall require any mental health plan that provides Medi-Cal services to enter into a memorandum of understanding with any Medi-Cal managed care plan that provides Medi-Cal health services to some of the same Medi-Cal recipients served by the mental health plan. The memorandum of understanding shall comply with applicable regulations.

(2) For purposes of this section, a “Medi-Cal managed care plan” means any prepaid health plan or Medi-Cal managed care plan contracting with the State Department of Health Services to provide services to enrolled Medi-Cal beneficiaries under Chapter 7

(commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9, or Part 4 (commencing with Section 101525) of Division 101 of the Health and Safety Code.

(b) The department shall require the memorandum of understanding to include all of the following:
(1) A process or entity to be designated by the local mental health plan to receive notice of actions, denials, or deferrals from the Medi-Cal managed care plan, and to provide any additional information requested in the deferral notice as necessary for a medical necessity determination.
(2) A requirement that the local mental health plan respond by the close of the business day following the day the deferral notice is received.

(c) The department may sanction a mental health plan pursuant to paragraph (1) of subdivision (~~e~~c) of Section ~~5775~~14715 for failure to comply with this section.

(d) This section shall apply to any contracts entered into, amended, modified, extended, or renewed on or after January 1, 2001.

Section 5777.6 of the Welfare and Institutions Code is renumbered as Section 14719:
(a) Each local mental health plan shall establish a procedure to ensure access to outpatient mental health services, as required by the Early Periodic Screening and Diagnostic Treatment program standards, for any child in foster care who has been placed outside his or her county of adjudication.

(b) The procedure required by subdivision (a) may be established through one or more of the following:
(1) The establishment of, and federal approval, if required, of, a statewide system or procedure.

(2) An arrangement between local mental health plans for reimbursement for services provided by a mental health plan other than the mental health plan in the county of adjudication and designation of an entity to provide additional information needed for approval or reimbursement. This arrangement shall not require providers who are already credentialed or certified by the mental health plan in the beneficiary's county of residence to be credentialed or certified by, or to contract with, the mental health plan in the county of adjudication.
(3) Arrangements between the mental health plan in the county of adjudication and mental health providers in the beneficiary's county of residence for authorization of, and reimbursement for, services. This arrangement shall not require providers credentialed or certified by, and in good standing with, the mental health plan in the beneficiary's county of residence to be credentialed or certified by the mental health plan in the county of adjudication.

(c) The department shall collect and keep statistics that will enable the department to compare access to outpatient specialty mental health services by foster children placed in their county of adjudication with access to outpatient specialty mental health services by foster children placed outside of their county of adjudication.

Section 5777.7 of the Welfare and Institutions Code is renumbered as Section 14720:

(a) In order to facilitate the receipt of medically necessary specialty mental health services by a foster child who is placed outside his or her county of original jurisdiction, the ~~State Department of Mental Health~~department shall take all of the following actions:
(1) On or before July 1, 2008, create all of the following items, in consultation with stakeholders, including, but not limited to, the California Institute for Mental Health, the Child and Family Policy Institute, the California Mental Health Directors Association, and the California Alliance of Child and Family Services:
(A) A standardized contract for the purchase of medically necessary specialty mental health services from organizational providers, when a contract is required.

(B) A standardized specialty mental health service authorization procedure.
(C) A standardized set of documentation standards and forms, including, but not limited to, forms for treatment plans, annual treatment plan updates, day treatment intensive and day treatment rehabilitative progress notes, and treatment authorization requests.
(2) On or before January 1, 2009, use the standardized items as described in paragraph (1) to provide medically necessary specialty mental health services to a foster child who is placed outside his or her county of original jurisdiction, so that organizational providers who are already certified by a mental health plan are not required to be additionally certified by the mental health plan in the county of original jurisdiction.
(3)(A) On or before January 1, 2009, use the standardized items described in paragraph (1) to provide medically necessary specialty mental health services to a foster child placed outside his or her county of original jurisdiction to constitute a complete contract, authorization procedure, and set of documentation standards and forms, so that no additional documents are required.
(B) Authorize a county mental health plan to be exempt from subparagraph (A) and have an addendum to a contract, authorization procedure, or set of documentation standards and forms, if the county mental health plan has an externally placed requirement, such as a requirement from a federal integrity agreement, that would affect one of these documents.
(4) Following consultation with stakeholders, including, but not limited to, the California Institute for Mental Health, the Child and Family Policy Institute, the California Mental Health Directors Association, the California State Association of Counties, and the California Alliance of Child and Family Services, require the use of the standardized contracts, authorization procedures, and documentation standards and forms as specified in paragraph (1) in the 2008-09 state-county mental health plan contract and each state-county mental health plan contract thereafter.
(5) The mental health plan shall complete a standardized contract, as provided in paragraph (1), if a contract is required, or another mechanism of payment if a contract is not required, with a provider or providers of the county's choice, to deliver approved specialty mental health services for a specified foster child, within 30 days of an approved treatment authorization request.

(b) The California Health and Human Services Agency shall coordinate the efforts of the ~~State Department of Mental Health~~department and the State Department of Social Services to do all of the following:

(1) Participate with the stakeholders in the activities described in this section.

(2) During budget hearings in 2008 and 2009, report to the Legislature regarding the implementation of this section and subdivision (c) of Section ~~5777.6~~14719.

(3) On or before July 1, 2008, establish the following, in consultation with stakeholders, including, but not limited to, the California Mental Health Directors Association, the California Alliance of Child and Family Services, and the County Welfare Directors Association of California:

(A) Informational materials that explain to foster care providers how to arrange for mental health services on behalf of the beneficiary in their care.

(B) Informational materials that county child welfare agencies can access relevant to the provision of services to children in their care from the out-of-county local mental health plan that is responsible for providing those services, including, but not limited to, receiving a copy of the child's treatment plan within 60 days after requesting services.

(C) It is the intent of the Legislature to ensure that foster children who are adopted or placed permanently with relative guardians, and who move to a county outside their original county of residence, can access mental health services in a timely manner. It is the intent of the Legislature to enact this section as a temporary means of ensuring access to these services, while the appropriate stakeholders pursue a long-term solution in the form of a change to the Medi-Cal Eligibility Data System that will allow these children to receive mental health services through their new county of residence.

Section 5778 of the Welfare and Institutions Code is amended and renumbered as Section 14721:

(a) This section shall be limited to specialty mental health services reimbursed through a fee-for-service payment system.

(b) The following provisions shall apply to matters related to specialty mental health services provided under the Medi-Cal specialty mental health services waiver, including, but not limited to, reimbursement and claiming procedures, reviews and oversight, and appeal processes for mental health plans (MHPs) and MHP subcontractors.

(1) During the initial phases of the implementation of this part, as determined by thedepartment, the MHP contractor and subcontractors shall submit claims under the Medi-Cal program for eligible services on a fee-for-service basis.

(2) A qualifying county may elect, with the approval of the department, to operate under the requirements of a capitated, integrated service system field test pursuant to Section ~~5719.5~~14722 rather than this part, in the event the requirements of the two programs conflict. A county that elects to operate under that section shall comply with all other provisions of this part that do not conflict with that section.

(3)(A) No sooner than October 1, 1994, state matching funds for Medi-Cal fee-for-service acute psychiatric inpatient services, and associated administrative days, shall be transferred to the department. No later than July 1, 1997, ~~upon agreement between the department and the State Department of Health Care Services,~~ state matching funds for the remaining Medi-Cal fee-for-service mental health services and the state matching funds associated with field test counties under Section ~~5719.5~~14722 shall be transferred to the department.

(B) The department, in consultation with ~~the State Department of Health Care Services,~~ a statewide organization representing counties, and a statewide organization representing health maintenance organizations shall develop a timeline for the transfer of funding and responsibility for fee-for-service mental health services from Medi-Cal managed care plans to MHPs. In developing the timeline, the department shall develop screening, referral, and coordination guidelines to be used by Medi-Cal managed care plans and MHPs.

~~(4)(A)(i) A MHP subcontractor providing specialty mental health services shall be financially responsible for federal audit exceptions or disallowances to the extent that these exceptions or disallowances are based on the MHP subcontractor's conduct or determinations.~~

~~(ii) The state shall be financially responsible for federal audit exceptions or disallowances to the extent that these exceptions or disallowances are based on the state's conduct or determinations. The state shall not withhold payment from a MHP for exceptions or disallowances that the state is financially responsible for pursuant to this clause.~~

~~(iii) A MHP shall be financially responsible for state audit exceptions or disallowances to the extent that these exceptions or disallowances are based on the MHP's conduct or determinations. A MHP shall not withhold payment from a MHP subcontractor for exceptions or disallowances for which the MHP is financially responsible pursuant to this clause.~~

~~(B) For purposes of subparagraph (A), a "determination" shall be shown by a written document expressly stating the determination, while "conduct" shall be shown by any credible, legally admissible evidence.~~

~~(C) The department and the State Department of Health Care Services shall work jointly with MHPs in initiating any necessary appeals. The department may invoice or offset the amount of any federal disallowance or audit exception against subsequent claims from the MHP or MHP subcontractor. This offset may be done at any time, after the audit exception or disallowance has been withheld from the federal financial participation claim made by the State Department of Health Care Services. The maximum amount that may be withheld shall be 25 percent of each payment to the plan or subcontractor.~~

(~~5~~4)(A) Oversight by the department of the MHPs and MHP subcontractors may include client record reviews of Early Periodic Screening Diagnosis and Treatment (EPSDT) specialty mental health services under the Medi-Cal specialty mental health services waiver in addition to other audits or reviews that are conducted.

(B) The department may contract with an independent, nongovernmental entity to conduct client record reviews. The contract awarded in connection with this section shall be on a competitive bid basis, pursuant to the Department of General Services contracting requirements, and shall meet both of the following additional requirements:

(i) Require the entity awarded the contract to comply with all federal and state privacy laws, including, but not limited to, the federal Health Insurance Portability and

Accountability Act (HIPAA; 42 U.S.C. Sec. 1320d et seq.) and its implementing regulations, the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), and Section 1798.81.5 of the Civil Code. The entity shall be subject to existing penalties for violation of these laws.

(ii) Prohibit the entity awarded the contract from using, selling, or disclosing client records for a purpose other than the one for which the record was given.

(C) For purposes of this paragraph, the following terms shall have the following meanings:

(i) “Client record” means a medical record, chart, or similar file, as well as other documents containing information regarding an individual recipient of services, including, but not limited to, clinical information, dates and times of services, and other information relevant to the individual and services provided and that evidences compliance with legal requirements for Medi-Cal reimbursement.

(ii) “Client record review” means examination of the client record for a selected individual recipient for the purpose of confirming the existence of documents that verify compliance with legal requirements for claims submitted for Medi-Cal reimbursement.

(D) The department shall recover overpayments of federal financial participation from MHPs within the timeframes required by federal law and regulation and return those funds ~~to the State Department of Health Care Services~~ for repayment to the federal Centers for Medicare and Medicaid Services. The department shall recover overpayments of General Fund moneys utilizing the recoupment methods and timeframes required by the State Administrative Manual.

(~~6~~5)~~(A)~~ The department, in consultation with mental health stakeholders, the California Mental Health Directors Association, and MHP subcontractor representatives, shall provide an appeals process that specifies a progressive process for resolution of disputes about claims or recoupments relating to specialty mental health services under the Medi-Cal specialty mental health services waiver.

(B) The department shall provide MHPs and MHP subcontractors the opportunity to directly appeal findings in accordance with procedures that are similar to those described in Article 1.5 (commencing with Section 51016) of Chapter 3 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations, until new regulations for a

progressive appeals process are promulgated. When an MHP subcontractor initiates an appeal, it shall give notice to the MHP. The department shall propose a rulemaking package by no later than the end of the 2008-09 fiscal year to amend the existing appeals process. The reference in this subparagraph to the procedures described in Article 1.5 (commencing with Section 51016) of Chapter 3 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations, shall only apply to those appeals addressed in this subparagraph.

(C) The department shall develop regulations or other similar instructions as necessary to implement this paragraph.

(~~7~~6) ~~The department shall assume the applicable program oversight authority formerly provided by the State Department of Health Care Services, including, but not limited to, the oversight of utilization controls as specified in Section 14133.~~ The MHP shall include a requirement in any subcontracts that all inpatient subcontractors maintain necessary licensing and certification. MHPs shall require that services delivered by licensed staff are within their scope of practice. Nothing in this part shall prohibit the MHPs from establishing standards that are in addition to the minimum federal and state requirements, provided that these standards do not violate federal and state Medi-Cal requirements and guidelines.

(~~8~~7)(a) Subject to federal approval and consistent with state requirements, the MHP may negotiate rates with providers of mental health services.

(~~9~~b) Under the fee-for-service payment system, any excess in the payment set forth in the contract over the expenditures for services by the plan shall be spent for the provision of specialty mental health services under the Medi-Cal specialty mental health service waiver and related administrative costs.

(~~10~~8) Nothing in this part shall limit the MHP from being reimbursed appropriate federal financial participation for any qualified services even if the total expenditures for service exceeds the contract amount with the department. Matching nonfederal public funds shall be provided by the plan for the federal financial participation matching requirement.

(c) This subdivision shall apply to managed mental health care funding allocations and risk-sharing determinations and arrangements

(1) The department shall allocate and distribute annually the full appropriated amount to each MHP for the managed mental health care program, exclusive of the EPSDT specialty mental health services program, provided under the mental health services waiver. The allocated funds shall be considered to be funds of the plan to be used as specified in this part.

~~(2) Each fiscal year the state matching funds for Medi-Cal specialty mental health services shall be included in the annual budget for the department. The amount included shall be based on historical cost, adjusted for changes in the number of Medi-Cal beneficiaries and other relevant factors. The appropriation for funding the state share of the costs for EPSDT specialty mental health services provided under the Medi-Cal specialty mental health services waiver shall only be used for reimbursement payments of claims for those services.~~

(~~3~~2) Initially, the MHP shall use the fiscal intermediary of the Medi-Cal program of the ~~State Department of Health Care Services~~ department for the processing of claims for inpatient psychiatric hospital services and may be required to use that fiscal intermediary for the remaining mental health services. The providers for other Short-Doyle Medi-Cal services shall not be initially required to use the fiscal intermediary but may be required to do so on a date to be determined by the department. The department and its MHPs shall be responsible for the initial incremental increased matching costs of the fiscal intermediary for claims processing and information retrieval associated with the operation of the services funded by the transferred funds.

(~~4~~3) The goal for funding of the future capitated system shall be to develop statewide rates for beneficiary, by aid category and with regional price differentiation, within a reasonable time period. The formula for distributing the state matching funds transferred to the department for acute inpatient psychiatric services to the participating counties shall be based on the following principles:

(A) Subject to appropriation,Medi-Cal state General Fund matching dollars shall be distributed to counties based on historic Medi-Cal acute inpatient psychiatric costs for

the county's beneficiaries and on the number of persons eligible for Medi-Cal in that county.

(B) All counties shall receive a baseline based on historic and projected expenditures up to October 1, 1994.

(C) Projected inpatient growth for the period October 1, 1994, to June 30, 1995, inclusive, shall be distributed to counties below the statewide average per eligible person on a proportional basis. The average shall be determined by the relative standing of the aggregate of each county's expenditures of mental health Medi-Cal dollars per beneficiary. Total Medi-Cal dollars shall include both fee-for-service Medi-Cal and Short-Doyle Medi-Cal dollars for both acute inpatient psychiatric services, outpatient mental health services, and psychiatric nursing facility services, both in facilities that are not designated as institutions for mental disease and for beneficiaries who are under 22 years of age and beneficiaries who are over 64 years of age in facilities that are designated as institutions for mental disease.

~~(D) There shall be funds set aside for a self-insurance risk pool for small counties. The department may provide these funds directly to the administering entity designated in writing by all counties participating in the self-insurance risk pool. The small counties shall assume all responsibility and liability for appropriate administration of these funds. For purposes of this subdivision, “small counties” means counties with less than 200,000 population. Nothing in this paragraph shall in any way obligate the state or the department to provide or make available any additional funds beyond the amount initially appropriated and set aside for each particular fiscal year, unless otherwise authorized in statute or regulations, nor shall the state or the department be liable in any way for mismanagement of loss of funds by the entity designated by the counties under this paragraph.~~

~~(5) The allocation method for state funds transferred for acute inpatient psychiatric services shall be as follows:~~

~~(A) For the 1994-95 fiscal year, an amount equal to 0.6965 percent of the total shall be transferred to a fund established by small counties. This fund shall be used to reimburse MHPs in small counties for the cost of acute inpatient psychiatric services in excess of the funding provided to the MHP for risk reinsurance, acute inpatient psychiatric~~

~~services and associated administrative days, alternatives to hospital services as approved by participating small counties, or for costs associated with the administration of these moneys. The methodology for use of these moneys shall be determined by the small counties, through a statewide organization representing counties, in consultation with the department.~~

~~(B) The balance of the transfer amount for the 1994-95 fiscal year shall be allocated to counties based on the following formula:~~

~~County Percentage~~

~~Alameda 3.5991~~

~~Alpine .0050~~

~~Amador .0490~~

~~Butte .8724~~

~~Calaveras .0683~~

~~Colusa .0294~~

~~Contra Costa 1.5544~~

~~Del Norte .1359~~

~~El Dorado .2272~~

~~Fresno 2.5612~~

~~Glenn .0597~~

~~Humboldt .1987~~

~~Imperial .6269~~

~~Inyo .0802~~

~~Kern 2.6309~~

~~Kings .4371~~

~~Lake .2955~~

~~Lassen .1236~~

~~Los Angeles 31.3239~~

~~Madera .3882~~

~~Marin 1.0290~~

~~Mariposa .0501~~

~~Mendocino .3038~~

~~Merced .5077~~

~~Modoc .0176~~

~~Mono .0096~~

~~Monterey .7351~~

~~Napa .2909~~

~~Nevada .1489~~

~~Orange 8.0627~~

~~Placer .2366~~

~~Plumas .0491~~

~~Riverside 4.4955~~

~~Sacramento 3.3506~~

~~San Benito .1171~~

~~San Bernardino 6.4790~~

~~San Diego 12.3128~~

~~San Francisco 3.5473~~

~~San Joaquin 1.4813~~

~~San Luis Obispo .2660~~

~~San Mateo .0000~~

~~Santa Barbara .0000~~

~~Santa Clara 1.9284~~

~~Santa Cruz 1.7571~~

~~Shasta .3997~~

~~Sierra .0105~~

~~Siskiyou .1695~~

~~Solano .0000~~

~~Sonoma .5766~~

~~Stanislaus 1.7855~~

~~Sutter/Yuba .7980~~

~~Tehama .1842~~

~~Trinity .0271~~

~~Tulare 2.1314~~

~~Tuolumne .2646~~

~~Ventura .8058~~

~~Yolo .4043~~

(~~6~~4) The allocation method for the state funds transferred for ~~subsequent years for~~ acute inpatient psychiatric and other specialty mental health services shall be determined by the department in consultation with a statewide organization representing counties.

(~~7~~5) The allocation methodologies described in this section shall only be in effect while federal financial participation is received on a fee-for- service reimbursement basis. When federal funds are capitated, the department, in consultation with a statewide organization representing counties, shall determine the methodology for capitation consistent with federal requirements. The share of cost ratio arrangement for EPSDT specialty mental health services provided under the Medi-Cal specialty mental health services waiver between the state and the counties in existence during the 2007-08 fiscal year shall remain as the share of cost ratio arrangement for these services unless changed by statute.

(~~8~~6) The formula that specifies the amount of state matching funds transferred for the remaining Medi-Cal fee-for-service mental health services shall be determined by the departmentin consultation with a statewide organization representing counties. This formula shall only be in effect while federal financial participation is received on a fee-for-service reimbursement basis.

(~~9~~7)(A) For the managed mental health care program, exclusive of EPSDT specialty mental health services provided under the Medi-Cal specialty mental health services waiver, the department shall establish, by regulation, a risk-sharing arrangement between the department and ~~counties that contract with the department as~~ MHPs to provide an increase in the state General Fund allocation, subject to the availability of funds, to the MHP under this section, where there is a change in the obligations of the MHP required by federal or state law or regulation, or required by a change in the interpretation or implementation of any such law or regulation which significantly increases the cost to the MHP of performing under the terms of its contract.

(B) During the time period required to redetermine the allocation, payment to the MHP of the allocation in effect at the time the change occurred shall be considered an interim payment, and shall be subject to increase effective as of the date on which the change is effective.

(C) In order to be eligible to participate in the risk-sharing arrangement, the ~~county~~MHP shall demonstrate, to the satisfaction of the department, its commitment or plan of commitment of all annual funding identified in the total mental health resource base, from whatever source, but not including county funds beyond the required maintenance of effort, to be spent on specialty mental health services. This determination of eligibility shall be made annually. The department may limit the participation in a risk-sharing arrangement of any county that transfers funds from the mental health account to the social services account or the health services account, in accordance with Section 17600.20 during the year to which the transfers apply to MHP expenditures for the new obligation that exceed the total mental health resource base, as measured before the transfer of funds out of the mental health account and not including county funds beyond the required maintenance of effort. The department~~State Department of Mental Health~~ shall participate in a risk-sharing arrangement only after a county has expended its total annual mental health resource base.

~~(d)The following provisions govern the administrative responsibilities of the department and the State Department of Health Care Services~~:

~~(1) It is the intent of the Legislature that the department and the State Department of Health Care Services consult and collaborate closely regarding administrative functions related to and supporting the managed mental health care program in general, and the delivery and provision of EPSDT specialty mental health services provided under the Medi-Cal specialty mental health services waiver, in particular. To this end, the following provisions shall apply:~~

~~(A) Commencing in the 2009-10 fiscal year, and each fiscal year thereafter, the department shall consult with the State Department of Health Care Services and amend the interagency agreement between the two departments as necessary to include improvements or updates to procedures for the accurate and timely processing of Medi-~~

~~Cal claims for specialty mental health services provided under the Medi-Cal specialty mental health services waiver. The interagency agreement shall ensure that there are consistent and adequate time limits, consistent with federal and state law, for claims submitted and the need to correct errors.~~

~~(B) Commencing in the 2009-10 fiscal year, and each fiscal year thereafter, upon a determination by the department and the State Department of Health Care Services that it is necessary to amend the interagency agreement, the department and the State Department of Health Care Services shall process the interagency agreement to ensure final approval by January 1, for the following fiscal year, and as adjusted by the budgetary process.~~

~~(C) The interagency agreement shall include, at a minimum, all of the following:~~

~~(i) A process for ensuring the completeness, validity, and timely processing of Medi-Cal claims as mandated by the federal Centers for Medicare and Medicaid Services.~~

~~(ii) Procedures and timeframes by which the department shall submit complete, valid, and timely invoices to the State Department of Health Care Services, which shall notify the department of inconsistencies in invoices that may delay payments.~~

~~(iii) Procedures and timeframes by which the department shall notify MHPs of inconsistencies that may delay payment.~~

~~(2)(A)~~(d)The department shall consult with ~~the State Department of Health Care Services and~~ the California Mental Health Directors Association in February and September of each year to review the methodology used to forecast future trends in the provision of EPSDT specialty mental health services provided under the Medi-Cal specialty mental health services waiver, to estimate these yearly EPSDT specialty mental health services related costs, and to estimate the annual amount of funding required for reimbursements for EPSDT specialty mental health services to ensure relevant factors are incorporated in the methodology. ~~The estimates of costs and reimbursements shall include both federal financial participation amounts and any state General Fund amounts for EPSDT specialty mental health services provided under the State Medi-Cal specialty mental health services waiver. The department shall provide the State Department of Health Care Services the estimate adjusted to a cash basis.~~

~~(B) The estimate of annual funding described in subparagraph (A) shall, include, but not be limited to, the following factors:~~

~~(i) The impacts of interactions among caseload, type of services, amount or number of services provided, and billing unit cost of services provided.~~

~~(ii) A systematic review of federal and state policies, trends over time, and other causes of change.~~

~~(C) The forecasting and estimates performed under this paragraph are primarily for the purpose of providing the Legislature and the Department of Finance with projections that are as accurate as possible for the state budget process, but will also be informative and useful for other purposes. Therefore, it is the intent of the Legislature that the information produced under this paragraph shall be taken into consideration under paragraph (10) of subdivision (c).~~

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in this section by means of provider bulletins or notices, policy letters, or other similar instructions without taking regulatory action.

Section 5719.5 of the Welfare and Institutions Code is amended and renumbered as Section 14722:

(a) Notwithstanding any other provision of state law, and to the extent permitted by federal law, the ~~State Department of Mental Health~~department may~~, in consultation with the State Department of Health Services,~~ field test major components of a capitated, integrated service system of Medi-Cal mental health managed care in not less than two, and not more than five participating counties.

(b) County participation in the field test shall be at the counties' option.

(c) Counties eligible to participate in the field test described in subdivision (a) shall include either of the following:(1) Any county with an existing county organized health system.(2) Any county that has been designated for the development of a new county organized health system.

(d) The ~~State Department of Mental Health~~department, in consultation with ~~the State Department of Health Services~~, the counties selected for field testing, and groups representing mental health clients, their families and advocates, county mental health directors, and public and private mental health professionals and providers, shall develop, for the purpose of the field test, major components for an integrated, capitated service system of Medi-Cal mental health managed care, including, but not limited to, all of the following:

(1)(A) A definition of medical necessity.(B) The preliminary definition developed pursuant to this paragraph shall be submitted to the Legislature no later than February 1, 1994.

(2) Protocols for facilitating access and coordination of mental health, physical health, educational, vocational, and other supportive services for persons receiving services through the field test.

(3) Procedures for promoting quality assurance, performance monitoring measures and outcome evaluation, including measures of client satisfaction, and procedures for addressing beneficiary grievances concerning service denials, changes, or terminations.

(e) Counties participating in the field test shall report to ~~the State Department of Mental Health as~~ the department ~~deems necessary~~.

(f~~e~~) Counties participating in the field test shall do both of the following:

(1)(A) Explore, in consultation with the~~department~~~~State Department of Mental Health, the State Department of Health Services~~, and the California Mental Health Directors Association, rates for capitated, integrated Medi-Cal mental health managed care systems, using an actuarially sound ratesetting methodology.

(B) These rates shall be evaluated by the~~department~~~~State Department of Mental Health and the State Department of Health Care Services~~ to determine their fiscal impact, and shall result in no increase in cost to the General Fund, compared with the cost that would occur under the existing organization of Medi-Cal funded mental health services,

except for caseload growth and price increases as included in the Medi-Cal estimates prepared by the departmentState Department of Health Care Services and approved by the Department of Finance. In evaluating the fiscal impact of these rates, the departments shall take into account any shift in clients between Medi-Cal programs in which the nonfederal match is funded by state funds and those in which the match is funded by local funds.

(2) Demonstrate the appropriate fiscal relationship between county organized health systems for the federal medicaid program and integrated, capitated Medi-Cal mental health managed care programs.

Section 5778.3 of the Welfare and Institutions Code is renumbered as 14723:
Notwithstanding any other law, including subdivision (b) of Section 16310 of the Government Code, the Controller may use the moneys in the Mental Health Managed Care Deposit Fund for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Interest shall be paid on all moneys loaned to the General Fund from the Mental Health Managed Care Deposit Fund. Interest payable shall be computed at a rate determined by the Pooled Money Investment Board to be the current earning rate of the fund from which loaned. This subdivision does not authorize any transfer that will interfere with the carrying out of the object for which the Mental Health Managed Care Deposit Fund was created.

Section 5779 of the Welfare and Institutions Code is amended and renumbered as Section 14724:
(a) This section shall be limited to mental health services reimbursed through a capitated rate payment system.

(b) Upon mutual agreement, the department and the State Department of Health Services may combine the funds transferred under this part, other funds available pursuant to Chapter 5 (commencing with Section 17600) of Part 5 of Division 9, and federal financial participation funds to establish a contract for the delivery of mental

~~health services to Medi-Cal beneficiaries under a capitated rate payment system. The combining of funds shall be done in consultation with a statewide organization representing counties. The combined funding shall be the budget responsibility of the department.~~

~~(c) The department, in consultation with a statewide organization representing counties, shall establish a methodology for a capitated rate payment system that is consistent with federal requirements.~~

~~(d) Capitated rate payments shall be made on a schedule specified in the contract with the mental health plan.~~

~~(e) The department may levy any necessary fines and audit disallowances to mental health plans relative to operations under this part. The mental health plans shall be liable for all federal audit exceptions or disallowances based on the plan's conduct or determinations. The mental health plan shall not be liable for federal audit exceptions or disallowances based on the state's conduct or determinations. The departmentshall work jointly with the mental health plan in initiating any necessary appeals. The department may offset the amount of any federal disallowance or audit exception against subsequent payment to the mental health plan at any time. The maximum amount that may be withheld shall be 25 percent of each payment to the mental health plan.~~

~~Section 5780 of the Welfare and Institutions Code is amended and renumbered as Section 14725:~~

~~(a) This part shall only be implemented to the extent that the necessary federal waivers are obtained. The director shall execute a declaration, to be retained by the director, that a waiver necessary to implement any provision of this part has been obtained.~~

~~(b) This part shall become inoperative on the date that, and only if, the director executes a declaration, to be retained by the director, that more than 10 percent of all counties fail to become mental health plan contractors, and no acceptable alternative contractors are~~

~~available, or if more than 10 percent of all funds allocated for Medi-Cal mental health services must be administered by the department because no acceptable plan is available.~~

Section 5781 of the Welfare and Institutions Code is amended and renumbered as Section 14726:

(a) Notwithstanding any other provision of law, a mental health plan may enter into a contract for the provision of Medi-Calmental health services for Medi-Cal beneficiaries with a hospital that provides for a per diem reimbursement rate for services that include room and board, routine hospital services, and all hospital-based ancillary services and that provides separately for the attending mental health professional's daily visit fee. The payment of these negotiated reimbursement rates to the hospital by the mental health plan shall be considered payment in full for each day of inpatient psychiatric and hospital care rendered to a Medi-Cal beneficiary, subject to third-party liability and patient share of costs, if any.

(b) This section shall not be construed to allow a hospital to interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 of the Business and Professions Code or any other provision of law.

(c) For purposes of this section, “hospital” means a hospital that submits reimbursement claims for Medi-Cal psychiatric inpatient hospital services through the Medi-Cal fiscal intermediary ~~as permitted by subdivision (g) of Section 5778~~.

~~**Section 5782 of the Welfare and Institutions Code is amended and renumbered as Section 14727:**~~

~~The provisions of this part are subject to and shall be read as incorporating the authority and oversight responsibilities of the State Department of Health Care Services in its role as the single state agency for the Medicaid program in California. The provisions of this~~

~~part shall be implemented only to the extent that federal financial participation is available.~~

Section 5783 of the Welfare and Institutions Code is amended and renumbered as Section 14728:

(a) Each eligible public agency, as described in subdivision (b), may, in addition to reimbursement or other payments that the agency would otherwise receive for Medi-Cal specialty mental health services, receive supplemental Medi-Cal reimbursement to the extent provided for in this section.

(b) A public agency shall be eligible for supplemental reimbursement only if it is a county, city, city and county, or the University of California and if, consistent with Section ~~5778~~ 14721, it meets either or both of the following characteristics continuously during a state fiscal year:

(1) Provides, pursuant to the Medi-Cal Specialty Mental Health Services Consolidation Waiver (Number CA.17), as approved by the federal Centers for Medicare and Medicaid Services, specialty mental health services to Medi-Cal beneficiaries in one or more of its publically owned and operated facilities.

(2) Provides or subcontracts for specialty mental health services to Medi-Cal beneficiaries as a mental health plan (MHP) pursuant to this part.

(c)(1) Subject to paragraph (2), an eligible public agency's supplemental reimbursement pursuant to this section shall be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to paragraph (2) of subdivision (f).

(2) Notwithstanding paragraph (1), in computing an eligible public agency's reimbursement, in no instance shall the expenditures certified pursuant to paragraph (1) of subdivision (e), when combined with the amount received from other sources of payment and with reimbursement from the Medi-Cal program, including expenditures otherwise certified for purposes of claiming federal financial participation, exceed 100 percent of actual, allowable costs, as determined pursuant to California's Medicaid State Plan, for the specialty mental health services to which the expenditure relates.

Supplemental payment may be made on an interim basis until the time when actual, allowable costs are finally determined.
(3) The supplemental Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on specialty mental health services provided to Medi-Cal patients by each eligible public agency, on a per-visit basis, a per-procedure basis, a time basis, in one or more lump sums, or on any other federally permissible basis. The State Department of Health Care Services shall seek approval from the federal Centers for Medicare and Medicaid Services for the payment methodology to be utilized, and shall not make any payment pursuant to this section prior to obtaining that federal approval.

(d)(1) It is the intent of the Legislature in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the General Fund. The department ~~or the State Department of Health Care Services~~ may require an eligible public agency, as a condition of receiving supplemental reimbursement pursuant to this section, to enter into, and maintain, an agreement with the department for the purposes of implementing this section and reimbursing the department ~~and the State Department of Health Care Services~~ for the costs of administering this section.
(2) Expenditures submitted to the department ~~and to the State Department of Health Care Services~~ for purposes of claiming federal financial participation under this section shall have been paid only with funds from the public agencies described in subdivision (b) and certified to the state as provided in subdivision (e).

(e) An eligible public agency shall do all of the following:
(1) Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for the specialty mental health services are eligible for federal financial participation.
(2) Provide evidence supporting the certification as specified by the department ~~or by the State Department of Health Care Services.~~

(3) Submit data as specified by the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.
(4) Keep, maintain, and have readily retrievable, any records specified by the department or by the State Department of Health Care Services to fully disclose reimbursement amounts to which the eligible public agency is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

(f)(1) The ~~State Department of Health Care Services~~department shall promptly seek any necessary federal approvals for the implementation of this section. If necessary to obtain federal approval, the program shall be limited to those costs that the federal Centers for Medicare and Medicaid Services determines to be allowable expenditures under Title XIX of the federal Social Security Act (Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code). If federal approval is not obtained for implementation of this section, this section shall not be implemented.
(2) The ~~State Department of Health Care Services~~department shall submit claims for federal financial participation for the expenditures described in subdivision (e) related to specialty mental health services that are allowable expenditures under federal law.
(3) The ~~State Department of Health Care Services~~department shall, on an annual basis, submit any necessary materials to the federal Centers for Medicare and Medicaid Services to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.
(4) The department shall collaborate with the ~~State Department of Health Care Services~~department to ensure that the department's policies, procedures, data, and other relevant materials are available to the ~~State Department of Health Care Services~~department as may be required for the implementation and administration of this section and for the claiming of federal financial participation.

(g)(1) The director may adopt regulations as are necessary to implement this section. The adoption, amendment, repeal, or readoption of a regulation authorized by this subdivision shall be deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1

and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe specific facts showing the need for immediate action.
(2) As an alternative to the adoption of regulations pursuant to paragraph (1), and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement and administer this article, in whole or in part, by means of provider bulletins or similar instructions, without taking regulatory action, provided that no bulletin or similar instruction shall remain in effect after June 30, 2011. It is the intent that regulations adopted pursuant to paragraph (1) shall be in place on or before June 30, 2011.

Section 5719 of the Welfare and Institutions Code is renumbered as Section 14729:

Each public or private facility or agency providing local mental health services pursuant to a county performance contract plan shall make a written certification within 30 days after a patient is admitted to the facility as a patient or first given services by such a facility or agency, to the local mental health director of the county, stating whether or not each of these patients is presumed to be eligible for mental health services under the California Medical Assistance Program.

Section 14021.3 of the Welfare and Institutions Code is deleted:

~~The department shall amend the state plan for medical assistance under Medicaid pursuant to Section 1915(g) of Title 19 of the Social Security Act, as amended by Public Law 99-272 (42 U.S.C. Sec. 1396n(g)), to add case management services as a covered benefit under the Short-Doyle/Medi-Cal program, and shall submit the plan for federal approval by December 31, 1988, or, if the plan has not been submitted by that date, shall submit a letter to the Legislature by that date explaining the circumstances delaying the plan's submission.~~

~~Upon federal approval for federal financial assistance, the department, in consultation with the State Department of Mental Health, shall define case management services, shall establish the standards under which case management services qualify as a~~

~~Short-Doyle/Medi-Cal reimbursable service, and shall develop an appropriate rate of reimbursement, subject to utilization controls.~~

~~It is the intent of the Legislature that at least 50 percent of the total state dollars that are offset as a result of the federal funds received for case management services be redirected to services for those persons identified in Section 14132.44 and that the remainder of these funds be redirected to services under the jurisdiction of the Health and Welfare Agency for persons other than those persons identified in Section 14132.44.~~

Section 14021.3 of the Welfare and Institutions Code is amended:

The department shall amend the state plan for medical assistance under Medicaid pursuant to Section 1915(g) of Title 19 of the Social Security Act, as amended by Public Law 99-272 (42 U.S.C. Section 1396n(g)), to add case management services as a benefit under the Short-Doyle Medi-Cal mental health programs for persons served by the ~~State Department of Mental Health~~ department and Short-Doyle Medi-Cal mental health programs.

Section 14021.4 of the Welfare and Institutions Code is amended:

(a) The department ~~State Department of Mental Health~~ shall prepare by January 15, 1991, amendments to California's plan for federal Medi-Cal grants for medical assistance programs, pursuant to Subchapter XIX (commencing with Section 1396) of Title 42 of the United States Code, to accomplish the following objectives:

(1) Expansion of the location and type of therapeutic services offered to the mentally ill under Medi-Cal by the category of “other diagnostic, screening, preventative, and rehabilitative services” which is available to states under the Social Security Act (42 U.S.C. Sec. 1396d(a)(13); 42 C.F.R . 440.130).

(2) Expansion of federal financial participation in the costs of community mental health services provided by local Short-Doyle community mental health programs or under contract to local Short-Doyle community mental health programs.

(3) Expansion of the location where reimbursable Short-Doyle Medi-Cal mental health services can be provided, including home, school, and community based sites.

(4) Expansion of federal financial participation for services which meet the rehabilitation needs of severely mentally ill consumers, including, but not limited to, medication management, functional rehabilitation assessments of clients, and rehabilitative services which include remedial services directed at restoration to the highest possible functional level for persons with psychiatric disabilities and maximum reduction of symptoms of mental illness.
(5) Improvement of fiscal systems and accountability structures for Short-Doyle Medi-Cal and Short-Doyle costs and rates, with the goal of achieving federal fiscal requirements.

(b) This Short-Doyle Medi-Cal state plan revision shall be completed with review and comments by the California ~~Conference of Local~~ Mental Health Directors Association and other appropriate groups. The addition of the rehabilitative option shall be limited to Short-Doyle providers certified to provide Medi-Cal under this option.

(c) The department ~~State Department of Health Services~~ shall review the state plan revision for ~~m~~Medicaid services ~~as recommended by the State Department of Mental Health. If~~ to ~~ensure~~ the state plan amendment satisfies published federal requirements for these amendments. ~~and if~~ Ifthedepartment ~~State Department of Health Care Services~~ has approved and submitted to the ~~Health Care Financing Administration~~Centers for Medicare and Medicaid Services a plan of correction for audit issues identified for the Short-Doyle Medi-Cal program, then the department shall promptly pursue federal adoption of the state plan revision. If the department ~~State Department of Health Services~~ does not recommend adoption of the revision, it shall report on the financial and programmatic implications of the proposal and the reasons for the rejection to the Joint Legislative Budget Committee by July 1, 1991.

(d) The state and local funds required to match federal financial participation shall include, but not be limited to, Short-Doyle Medi-Cal and county matching funds. Additional General Fund moneys for this purpose shall be subject to appropriation in the annual Budget Act.

(e) It is the intent of the Legislature that the rehabilitation option of the state medicaid plan be implemented to expand and provide flexibility to treatment services and to increase the federal participation without increasing the costs to the General Fund.

(f) It is the intent of the Legislature that addition of the rehabilitation option as a Short-Doyle Medi-Cal benefit shall become operative only after the ~~Health Care Financing Administration~~Centers for Medicare and Medicaid Serviceshas reviewed and approved the state plan revision submitted by the department ~~State Department of Health Care Services~~, a plan of correction approved by the department for audit issues identified for the Short-Doyle Medi-Cal program has been submitted, and the requirements of this section have been fully satisfied.

(g) If the Medi-Cal state plan revision required by this section is approved by the department ~~State Department of Health Services~~, and submitted for federal approval, tThe State department ~~Department of Mental Health Care Services~~ shall review and revise the quality assurance standards and guidelines required by Article 5 (commencing with Section 4070) of Chapter 2 of Division 4 to meet the necessary standards to assure that quality services are delivered to the eligible population. This review shall include, but not be limited to, appropriate use of mental health professionals, including psychiatrists, in the treatment and rehabilitation of clients under this model. The existing quality assurance standards and guidelines shall remain in effect until the adoption of the new quality assurance standards and guidelines.

(h) Consistent with services offered to persons who are mentally ill under the Medi-Cal program, as required by this section, it is the intent of the Legislature for the department ~~State Department of Mental Health Care Services, working collaboratively with the department,~~ to include care and treatment of persons with mental disorders who are eligible for the Medi-Cal program in facilities with a bed capacity of 16 beds or less.

Section 14021.5 of the Welfare and Institutions Code is amended to read:

(a) Notwithstanding any other provision of law, rates for reimbursing Short-DoyleMedi-Cal mental health and drug services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries under the Short-DoyleMedi-Cal program shall continue to be based on the upper limits allowable under federal law and regulations for services provided prior to July 1, 1980, on the lower of reasonable cost and customary charges for services provided July 1, 1980, through June 30, 1982, and on the lowest of reasonable cost, customary charges, and rates paid by the Short-DoyleMedi-Cal program for services provided July 1, 1982, through June 30, 1984.

(b) The Legislature hereby states and declares that this section does not constitute a change in, but is declaratory of, existing law, and that rates for reimbursing Short-DoyleMedi-Cal mental health and drug services to Medi-Cal beneficiaries under the Short-DoyleMedi-Cal program in previous fiscal years were based upon the lower of reasonable costs or customary charges.

(c) The departmentState Department of Health Services, after consulting with the State Department of Mental Health and the State Department of Alcohol and Drug Programs, in regard to their respective programs, shall promulgate emergency regulations or other similar instructions relating to claims submission and establishing rates and a ratesetting methodology for determining reimbursement of Short-Doyle Medi-Cal mental health and drug services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries under the State Department of Mental Health and the State Department of Alcohol and Drug Programs' programs respectively. The methodology and rates shall reflect the most recently completed cost reports and shall be effective commencing July 1, 1984.

(d) Notwithstanding any other provision of law, rates for reimbursing Short-Doyle Medi-Cal mental health services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries under the programs administered by the State Department of Mental Health shall be effective from July 1 through June 30 of the fiscal year in which these rates are established.

(e) Notwithstanding any other provision of law, rates for reimbursing drug services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries under the programs ~~administered by the State Department of Alcohol and Drug Programs~~ shall be effective from July 1 through June 30 of the fiscal year in which these rates are established.

(f) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in this section by means of provider bulletins or notices, policy letters, or other similar instructions without taking regulatory action.

Section 14053.3 of the Welfare and Institutions Code is amended to read:

As federal financial participation reimbursement is not allowed for ancillary services provided to persons residing in facilities that have been found to be institutions for mental disease (IMD), and since, consistent with Part 2 (commencing with Section 5600) of Division 5 and Chapter 6 (commencing with Section 17600) of Part 5, counties are financially responsible for mental health services and related ancillary services provided to persons through county mental health programs when Medi-Cal reimbursement is not available, when it is determined that Medi-Cal reimbursement has been paid for ancillary services for residents of IMDs, both the federal financial participation reimbursement and any state funds paid for the ancillary services provided to residents of IMDs shall be recovered from counties by the ~~State Department of Mental Health~~department in accordance with applicable state and federal statutes and regulations.

Section 14108.1 of the Welfare and Institutions Code is amended to read:

Any recipient receiving care in a nursing facility under this chapter, as part of a certified special treatment program for mentally disordered persons, or as a part of a mental health therapeutic and rehabilitative program approved and certified by a local mental health director, is entitled to be temporarily absent from those facilities. The department

~~State Department of Health Services~~ shall~~, with consultation from the State Department of Mental Health,~~ develop regulations within 60 days of the effective date of this act establishing the periods of time and conditions under which temporary absences shall be permitted. These regulations shall require that absences be in accordance with an individual patient care plan and also provide for absences due to hospitalization for an acute condition. The limits on temporary leaves of absence established by the ~~State Department of Health Services~~ department by regulation shall not be less than 30 days per year.

During these temporary absences, the ~~State Department of Health~~Services department shall reimburse the facility for the cost of maintaining the vacant accommodations at a rate to be determined by the department which shall be less than the normal reimbursement rate.

Section 14110.15 of the Welfare and Institutions Code is amended to read:

(a) The department shall develop, collect, and maintain, in an electronic format, all data elements in the minimum data set specified by the federal government. The data base shall incorporate the data required for preadmission screening and annual resident reviews, and Medi-Cal treatment authorization requests. The department shall make the format of this new data base available to the public.

(b) All skilled nursing facilities and nursing facilities required by federal law to complete the minimum data set form shall provide the data to the department in a manner and form prescribed by the director. The director may require that the submission of that data shall be in an electronic format.

(c) The department shall design the minimum data set data base in a manner that maintains resident confidentiality and that allows the use of the data by other authorized state agencies, including, but not limited to, the Office of Statewide Health Planning and Development ~~and the Department of Mental Health~~. To the extent possible, those other state agencies shall obtain the minimum data set and preadmission screening and

annual resident review data from the department's data base established and maintained pursuant to this section.

(d) To the fullest extent possible, the department shall use the minimum data set data base to meet the requirements of the current treatment authorization request review process and shall automate use of the minimum data set information for that purpose.

(e) This section shall not be construed to prohibit the department or any other state agency from requiring additional information that is not available from the minimum data set data base in order to meet other data needs.

(f) The department shall implement this section no later than the date specified by the federal government for facility completion of automation of the minimum data set data. The department shall, within a reasonable time, make necessary system changes to begin the use of the automated minimum data set data to meet its treatment authorization and preadmission screening and annual resident review data requirements. To the fullest extent possible, these system changes shall be anticipated and commenced in advance of the federal government's final implementation date.

(g) The system shall be developed and implemented in consultation with representatives of the long-term care industry and other interested parties, such as physicians and other health care professionals.

(h) The department shall implement the development of the minimum data set data base only if federal funds are available for that purpose. Development of the data system applications for use of the automated minimum data set data base by the department are subject to federal approval and federal financial participation for the affected systems.

Section14132.24 of the Welfare and Institutions Code is amended to read:

(a) The department shall develop and implement a program to provide a community-living support benefit to eligible Medi-Cal beneficiaries. The department shall submit any waiver application, modification of any existing waiver, or amendment to the Medicaid state plan, that is necessary to provide this benefit, and shall implement the benefit only to the extent that federal financial participation is available.

(b) The community-living support benefit shall include both of the following:
(1)(A) Reimbursement for an array of health-related and psychosocial services provided or coordinated at community-based housing sites that enable beneficiaries to remain in the least restrictive and most homelike environment while receiving the health-related services, including personal care and psychosocial services, necessary to protect their health and well-being. These community-based housing units may include, but are not limited to, the living area or unit within a facility that is specifically designed to provide ongoing assisted living services, licensed residential care facilities for the elderly, publicly funded senior and disabled housing projects, or supportive housing sites that serve chronically homeless individuals with chronic or disabling health conditions.

(B) For purposes of this section, “assisted living services” includes, but is not limited to, assistance with personal activities of daily living, including dressing, feeding, toileting, bathing, grooming, mobility, and associated tasks, to help provide for and maintain physical and psychological comfort.

(2) Access to community-living support services provided or coordinated at the community-based housing site, including, but not limited to, the personal care and health services specified in paragraph (8) of subdivision (a) of Section 1788 of the Health and Safety Code, and the health related support services specified in Section 53290 of the Health and Safety Code.

(c) Services available through the community-living support benefit shall not duplicate services available through the Medi-Cal state plan, other Medi-Cal waivers, or other programs financed by the state.

(d) An individual shall be eligible for the community-living support benefit if he or she is eligible for the Medi-Cal program, is a resident of San Francisco who would otherwise be homeless, living in shelters, or institutionalized, and meets one or both of the following criteria:

(1) The ~~State Department of Mental Health~~department determines that he or she would benefit from supportive housing, as defined in subdivision (c) of Section 53260 of the Health and Safety Code.

(2) The department determines that he or she is eligible for placement in a skilled nursing facility, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, or an intermediate care facility, as defined in subdivision (d) of that section.

(e) The department may modify the eligibility criteria specified in subdivision (d), if needed, to qualify the community-living support benefit for federal financial participation.

(f) The department shall seek to maximize resources for community-based housing by coordinating the community-living support benefit with existing efforts to coordinate care, improve health outcomes, and reduce long-term care costs for the targeted population.

(g) This section shall be implemented only upon adoption of a resolution by the Board of Supervisors of the City and County of San Francisco providing county funds for use by the state to match federal Medicaid funds to receive federal funds for services provided under the waiver specified in this section, and for any costs associated with implementing and monitoring the waiver, to limit additional state costs.

Section 14132.73 of the Welfare and Institutions Code is amended to read:

The ~~State Department of Health Care Services~~department shall allow psychiatrists to receive fee-for-service Medi-Cal reimbursement for services provided through

telemedicine until June 30, 2004, or until the ~~State Department of Mental Health Care Services~~ department and mental health plans, in collaboration with stakeholders, develop a method for reimbursing psychiatric services provided through telemedicine that is administratively feasible for the mental health plans, primary care providers, and psychiatrists providing the services, whichever occurs later.

Section 14167.1 of the Welfare and Institutions Code is amended to read:
For purposes of this article, the following definitions shall apply:

(a) “Acute psychiatric days” means the total number of Short-DoyleMedi-Cal administrative days, Short-DoyleMedi-Cal acute care days, acute psychiatric administrative days, and acute psychiatric acute days identified in the Final Medi-Cal Utilization Statistics for the 2008-09 state fiscal year as calculated by the department on September 15, 2008.

(b) “Converted hospital” means a private hospital that becomes a designated public hospital or a nondesignated public hospital after the implementation date, a nondesignated public hospital that becomes a private hospital or a designated public hospital after the implementation date, or a designated public hospital that becomes a private hospital or a nondesignated public hospital after the implementation date.

(c) “Current Section 1115 Waiver” means California's Medi-Cal Hospital/Uninsured Care Section 1115 Waiver Demonstration in effect on the effective date of the article.

(d) “Designated public hospital” shall have the meaning given in subdivision (d) of Section 14166.1 as that section may be amended from time to time.

(e) “General acute care days” means the total number of Medi-Cal general acute care days paid by the department to a hospital in the 2008 calendar year, as reflected in the state paid claims files on July 10, 2009.

(f) “High acuity days” means Medi-Cal coronary care unit days, pediatric intensive care unit days, intensive care unit days, neonatal intensive care unit days, and burn unit days paid by the department during the 2008 calendar year, as reflected in the state paid claims files on July 10, 2009.

(g) “Hospital inpatient services” means all services covered under Medi-Cal and furnished by hospitals to patients who are admitted as hospital inpatients and reimbursed on a fee-for-service basis by the department directly or through its fiscal intermediary. Hospital inpatient services include outpatient services furnished by a hospital to a patient who is admitted to that hospital within 24 hours of the provision of the outpatient services that are related to the condition for which the patient is admitted. Hospital inpatient services do not include services for which a managed health care plan is financially responsible.

(h) “Hospital outpatient services” means all services covered under Medi-Cal furnished by hospitals to patients who are registered as hospital outpatients and reimbursed by the department on a fee-for-service basis directly or through its fiscal intermediary. Hospital outpatient services do not include services for which a managed health care plan is financially responsible, or services rendered by a hospital-based federally qualified health center for which reimbursement is received pursuant to Section 14132.100.

(i)(1) “Implementation date” means the latest effective date of all federal approvals or waivers necessary for the implementation of this article and Article 5.22 (commencing with Section 14167.31), including, but not limited to, any approvals on amendments to contracts between the department and managed health care plans or mental health plans necessary for the implementation of this article. The effective date of a federal approval or waiver shall be the earlier of the stated effective date or the first day of the first quarter to which the computation of the payments or fee under the federal approval or waiver is applicable, which may be prior to the date that the federal approval or waiver is granted or the applicable contract is amended.

(2) If federal approval is sought initially for only the 2008-09 federal fiscal year and separately secured for subsequent federal fiscal years, the implementation date for the 2008-09 federal fiscal year shall occur when all necessary federal approvals have been secured for that federal fiscal year.

(j) “Individual hospital acute psychiatric supplemental payment” means the total amount of acute psychiatric hospital supplemental payments to a subject hospital for a quarter for which the supplemental payments are made. The “individual hospital acute psychiatric supplemental payment” shall be calculated for subject hospitals by multiplying the number of acute psychiatric days for the individual hospital for which a mental health plan was financially responsible by four hundred eighty-five dollars ($485) and dividing the result by 4.

(k)(1) “Managed health care plan” means a health care delivery system that manages the provision of health care and receives prepaid capitated payments from the state in return for providing services to Medi-Cal beneficiaries.

(2)(A) Managed health care plans include county organized health systems and entities contracting with the department to provide services pursuant to two-plan models and geographic managed care. Entities providing these services contract with the department pursuant to any of the following:
(i) Article 2.7 (commencing with Section 14087.3).
(ii) Article 2.8 (commencing with Section 14087.5).
(iii) Article 2.81 (commencing with Section 14087.96).
(iv) Article 2.91 (commencing with Section 14089).
(B) Managed health care plans do not include any of the following:
(i) Mental health plan contracting to provide mental health care for Medi-Cal beneficiaries pursuant to Part 2.5 (commencing with Section 5775) of Division 5.
(ii) Health plan not covering inpatient services such as primary care case management plans operating pursuant to Section 14088.85.

(iii) Long-Term Care Demonstration Projects for All-Inclusive Care for the Elderly operating pursuant to Chapter 8.75 (commencing with Section 14590).
(l) “Medi-Cal managed care days” means the total number of general acute care days, including well baby days, listed for the county organized health system and prepaid health plans identified in the Final Medi-Cal Utilization Statistics for the 2008-09 state fiscal year, as calculated by the department on September 15, 2008, except that the general acute care days, including well baby days, for the Santa Barbara Health Care Initiative shall be derived from the Final Medi-Cal Utilization Statistics for the 2007-08 state fiscal year.
(m) “Medicaid inpatient utilization rate” means Medicaid inpatient utilization rate as defined in Section 1396r-4 of Title 42 of the United States Code and as set forth in the final disproportionate share hospital eligibility list for the 2008-09 state fiscal year released by the department on October 22, 2008.

(n) “Mental health plan” means a mental health plan that contracts with the ~~State Department of Mental Health~~ department to furnish or arrange for the provision of mental health services to Medi-Cal beneficiaries pursuant to Part ~~2.5~~3 (commencing with Section ~~5775~~ 14715) of Division ~~5~~ 9.

(o) “New hospital” means a hospital that was not in operation under current or prior ownership as a private hospital, a nondesignated public hospital, or a designated public hospital for any portion of the 2008-09 state fiscal year.

(p) “Nondesignated public hospital” means either of the following:
(1) A public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2007, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.
(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's

annual financial disclosure report for the hospital's latest fiscal year ending in 2007, is operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(q) “Outpatient base amount” means the total amount of payments for hospital outpatient services made to a hospital in the 2007 calendar year, as reflected in state paid claims files on January 26, 2008.

(r) “Private hospital” means a hospital that meets all of the following conditions:
(1) Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.
(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2007.
(3) Does not satisfy the Medicare criteria to be classified as a long-term care hospital.
(4) Is a nonpublic hospital, nonpublic converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(s) “Subject federal fiscal year” means a federal fiscal year that ends after the implementation date and begins before December 31, 2010.

(t) “Subject fiscal quarter” means a fiscal quarter beginning on or after the implementation date and ending before January 1, 2011.

(u) “Subject fiscal year” means a state fiscal year that ends after the implementation date and begins before December 31, 2010.

(v) “Subject hospital” shall mean a hospital that meets all of the following conditions:

(1) Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.
(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2007.
(3) Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

(w) “Subject month” means a calendar month beginning on or after the implementation date and ending before January 1, 2011.

(x) “Upper payment limit” means a federal upper payment limit on the amount of the Medicaid payment for which federal financial participation is available for a class of service and a class of health care providers, as specified in Part 447 of Title 42 of the Code of Federal Regulations.

Section 14167.11 of the Welfare and Institutions Code is amended to read:
(a) The department shall increase payments to mental health plans for the subject fiscal years as set forth in this section. The aggregate amount of the increased payments for a subject fiscal quarter shall be the total of the individual hospital acute psychiatric supplemental payment amounts for all hospitals for which federal financial participation is available.

(b) For each subject fiscal quarter, the state shall make increased payments to each mental health plan. The department shall consider the composition of Medi-Cal enrollees in the mental health plan, the anticipated utilization of hospital services by the mental health plan's Medi-Cal enrollees, and other factors that the department determines are reasonable and appropriate to ensure access to high-quality hospital services by the mental health plan's enrollees.

(c) The state shall make increased payments to mental health plans exclusively for the purpose of making payments to hospitals, in order to support the availability of hospital mental health services and ensure access for Medi-Cal beneficiaries to hospital mental health services. The increased payments to mental health plans shall be made as follows:

(1) The increased payments shall commence on or before the later of the last day of the second month of the quarter in which federal approval is granted or the 45th day following the day on which federal approval is granted. Subsequent increased payments shall be made on the last day of the second month of each quarter. The last increased payments made pursuant to this section shall be made during November 2010.

(2) The increased payments made for the first quarter for which increased payments are made under this section shall include the sum of increased payments for all prior quarters for which payments are due under subdivision (b).

(3) The increased payments made during November 2010 shall include payments computed under subdivision (b) for all quarters in the 2010-11 subject fiscal year to the extent that federal financial participation is available for the payments.

(4) If all necessary federal approvals are not received on or before September 1, 2010, the department shall make semimonthly payments starting within one month of receipt of all necessary federal approvals until December 31, 2010.

(d) Each mental health plan shall expend, in the form of additional payments to hospitals, the increased payments it receives under this section, pursuant to Section 14167.12.

(e) In the event federal financial participation for a subject fiscal year is not available for all of the increased acute psychiatric payments determined for a quarter pursuant to this section for any reason, the increased payments mandated by this section for that quarter shall be reduced proportionately to the amount for which federal financial participation is available.

(f) Payments to mental health plans that would be paid in the absence of the payments made pursuant to this section shall not be reduced as a consequence of the payments under this section.

(g) Notwithstanding any other provision of this article or Article 5.22 (commencing with Section 14167.31), individual hospital acute psychiatric supplemental payments under this section and Section 14167.12 may be made directly by the department to hospitals in accordance with Section 14167.9 when federal law does not require that the payments be transmitted to the hospitals via mental health plans.

(h) The department may, as necessary, allocate money appropriated to it from the Hospital Quality Assurance Revenue Fund ~~to the State Department of Mental Health~~ for the purposes of making increased payments to mental health plans pursuant to this article.

(i) The amount, if any, by which the aggregate individual hospital acute psychiatric supplemental payment amounts for a subject fiscal quarter, including any carryover amount under this subdivision, exceeds the amount for which federal financial participation is available for that quarter due to the application of a federal upper payment limit shall be added to the aggregate individual hospital acute psychiatric supplemental payment amounts for the succeeding subject fiscal quarter. In the event there is a carryover amount for the subject fiscal quarter ending December 31, 2010, the amount shall be payable under this section for the quarter ending March 31, 2011, and, if necessary due to the application of a federal upper payment limit, the quarter ending June 30, 2011.

Section 14456.5 of the Welfare and Institutions Code is amended to read:

(a) For purposes of this section, Medi-Cal managed care plan means any prepaid health plan or Medi-Cal managed care plan contracting with the department to provide services to enrolled Medi-Cal beneficiaries under Chapter 7 (commencing with Section

14000) or this chapter, or Part 4 (commencing with Section 101525) of Division 101 of the Health and Safety Code.

(b) The department shall ensure that coverage is provided for medically necessary prescription medications and related medically necessary medical services that are prescribed by a local mental health plan provider, and are within the Medi-Cal scope of benefits, but are excluded from coverage under Part ~~2.5~~3 (commencing with Section ~~5775~~ 14715) of Division ~~5~~ 9, by doing, at least, all of the following:

(1) Requiring Medi-Cal managed care plans to comply with the following standards:
(A) The decision regarding responsibility and coverage for a prescription drug shall be made by the Medi-Cal managed care plan within 24 hours, or one business day, from the date the request for a decision is received by telephone or other telecommunication device.
(B) The decision regarding responsibility and coverage for services, such as laboratory tests, that are medically necessary because of medications prescribed by a mental health provider, shall be made by the Medi-Cal managed care plan within seven days following the date the request for a decision is received by telephone or other telecommunication device.
(C) If the decision of the Medi-Cal managed care plan on the request is a deferral because of a determination that the Medi-Cal managed care plan needs more information, the Medi-Cal managed care plan shall transmit notice of the deferral, by facsimile or by other telecommunication system, to the pharmacist or other service provider, to the prescribing mental health provider, and to a designated mental health plan representative. The notice shall set out with specificity what additional information is needed to make a medical necessity determination.
(D) Any denial of authorization or payment for a prescription medication or for any services such as laboratory tests that may be medically necessary because of medications ordered by a mental health plan provider shall set forth the reasons for the denial with specificity. The denial notice shall be transmitted by facsimile or other telecommunication system to the pharmacist or other service provider, to the

prescribing mental health provider, to a designated mental health plan representative, and by mail to the Medi-Cal beneficiary.
(E) For purposes of subsequent requests for a medication, the local mental health plan provider prescribing the prescription medication shall be treated as a plan provider under subdivision (a) of Section 1367.22 of the Health and Safety Code.
(F) If the decision cannot be made within five working days because of a request for additional information, any Medi-Cal managed care plan licensed pursuant to Division 2 (commencing with Section 1340) of the Health and Safety Code shall inform the enrollee as required by paragraph (5) of subdivision (h) of Section 1367.01 of the Health and Safety Code. In regard to any Medi-Cal managed care plan contract as described pursuant to subdivision (a) that is issued, amended, or renewed on or after January 1, 2001, with a plan not licensed pursuant to Division 2 (commencing with Section 1340) of the Health and Safety Code, if the decision cannot be made within five working days because of a request for additional information as specified in subparagraph (C), the plan shall notify the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization. All managed care plans shall, upon receipt of all information reasonably necessary for making the decision and that was requested by the plan, approve, modify, or deny the request for authorization within the timeframes specified in subparagraph (A) or (B), whichever applies.

(2) In consultation with the Medi-Cal managed care plans, the ~~State Department of Mental Health~~ department and local mental health plans establishing a process to recognize credentialing of local mental health plan providers, for the purpose of expediting approval of medications prescribed by a local mental health plan provider who is not contracting with the Medi-Cal managed care plan. In implementing this requirement, the Medi-Cal managed care plan shall not be required to violate licensure, accreditation, or certification requirements of other entities.

(3) Requiring any Medi-Cal managed care plan to enter into a memorandum of understanding with the local mental health plan. The memorandum of understanding shall comply with applicable regulations.

(c) The department may sanction a Medi-Cal managed care plan for violations of this section pursuant to Section 14088.23 or 14304.

(d) Every Medi-Cal managed care plan that provides prescription drug benefits and that maintains one or more drug formularies shall provide to members of the public, upon request, a copy of the most current list of prescription drugs on the formulary of the Medi-Cal managed care plan, by therapeutic category, with an indication of whether any drugs on the list are preferred over other listed drugs. If the Medi-Cal managed care plan maintains more than one formulary, the plan shall notify the requester that a choice of formulary lists is available.

(e) This section shall apply to any contracts entered into, amended, modified, or extended on or after January 1, 2001.

Sections14680 of the Welfare and Institutions Code is amended to read:

(a) The Legislature finds and declares that there is a need to establish a standard set of guidelines that governs the provision of managed Medi-Cal mental health services at the local level, consistent with federal law.

(b) Therefore, in order to ensure quality and continuity, and to efficiently utilize mental health services under the Medi-Cal program, there shall be developed mental health plans for the provision of those services that are consistent with guidelines established by the department~~State Department of Mental Health~~

(c) It is the intent of the Legislature that mental health plans be developed and implemented regardless of whether other systems of Medi-Cal managed care are implemented.

~~(d) It is further the intent of the Legislature that Sections 14681 to 14685, inclusive, shall not be construed to mandate the participation of counties in Medi-Cal managed mental health care plans.~~

Section 14681 of the Welfare and Institutions Code is amended to read:

The department ~~State Department of Health Care Services, in consultation with the State Department of Mental Health,~~ shall ensure that all contracts for Medi-Cal managed care include a process for screening, referral, and coordination with any mental health plan established pursuant to Section 14682, of medically necessary mental health care services.

~~**Section 14682 of the Welfare and Institutions Code is amended to read:**~~

~~(a) Notwithstanding any other provision of state law, and to the extent permitted by federal law, the State Department of Mental Healthshall be designated as the state agency responsible for development, consistent with the requirements of Section 4060, and implementation of mental health plans for Medi-Cal beneficiaries.~~

~~(b) The department shall convene a steering committee for the purpose of providing advice and recommendations on the development of Medi-Cal mental health managed care systems pursuant to subdivision (a). The committee shall include work groups to advise the department of major issues to be addressed in the managed mental health care plan. Representatives of concerned groups, including, but not limited to, beneficiaries, their families, providers, mental health professionals, statewide representatives of health care service plans, the California Mental Health Planning Council, public and private organizations, and county mental health directors, shall be invited to participate in the steering committee process.~~

Section 14683 of the Welfare and Institutions Code is amended to read:

The ~~State Department of Mental Health~~department shall ensure the following ~~in the development of mental health plans~~:

(a) That mental health plans include a process for screening, referral, and coordination with other necessary services, including, but not limited to, health, housing, and vocational rehabilitation services. For Medi-Cal eligible children, the mental health plans shall also provide coordination with education programs and any necessary medical or rehabilitative services, including, but not limited to, those provided under the California Children's Services Program (Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code) and the Child Health and Disability Prevention Program (Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code), and those provided by a fee-for-service provider or a Medi-Cal managed care plan. This subdivision shall not be construed to establish any higher level of service from a county than is required under existing law. The ~~county mental health department and the~~ mental health plan~~, if it is not the county department,~~ shall not be liable for the failure of other agencies responsible for the provision of non-mental health services to provide those services or to participate in coordination efforts.

(b) That mental health plans include a system of outreach to enable Medi-Cal beneficiaries and providers to participate in and access Medi-Cal mental health services under the plans, consistent with existing law.

(c) That standards for quality and access developed by the department~~, in consultation with the steering committee established pursuant to Section 14682,~~ are included in mental health plans serving Medi-Cal beneficiaries.

Section 14684.1 of the Welfare and Institutions Code is amended to read:

(a) The ~~State Department of Mental Health~~department shall establish a process for second level treatment authorization request appeals to review and resolve disputes between mental health plans and hospitals.

(b) When the department establishes an appeals process, the department shall comply with all of the following:
(1) The department shall review appeals initiated by hospitals and render decisions on appeals based on findings that are the result of a review of supporting documents submitted by mental health plans and hospitals.
(2) If the department upholds a mental health plan denial of payment of a hospital claim, a review fee shall be assessed on the provider.
(3) If the ~~State Department of Mental Health~~department reverses a mental health plan denial of payment of a hospital claim, a review fee shall be assessed on the mental health plan.
(4) If the department decision regarding a mental health plan denial of payment upholds the claim in part and reverses the claim in part, the department shall prorate the review fee between the parties accordingly.

(c) The amount of the review fees shall be calculated and adjusted annually. The methodology and calculation used to determine the fee amounts shall result in an aggregate fee amount that, in conjunction with any other outside source of funding for this function, may not exceed the aggregate annual costs of providing second level treatment authorization request reviews.

(d) Fees collected by the department shall be retained by the department and used to offset administrative and personnel services costs associated with the appeals process.

(e) The department may use the fees collected, in conjunction with other available appropriate funding for this function, to contract for the performance of the appeals process function.

Uncodified Section XX
The amendments to Welfare and Institutions Code sections 5711, 5716, 5718, 5719, 5719.5, 5720, 5721, 5722, 5723, 5723.5, 5724, 5775, 5776, 5777, 5777.5, 577.6, 5777.7, 5778, 5778.3, 5779, 5780, 5781, 5782, 5783,,14021.3, 14021.4, 14021.5,

14053.3, 14108.1, 14110.15, 14132.24, 14132.73, 14167.1, 14167.11, 14456.5, 14680, 14681, 14682, 14683, 14684.1 shall become operative June 30, 2012.